COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

Healthy Way LA
LOS ANGELES COUNTY

ELIGIBILITY APPEAL DECISION LETTER Healthy Way LA
OVERTURN DECISION

Date:

Name: ***[Insert Applicant Name or Representative]***:
Applicant's Name:
Address:
City, State, Zip

HWLA Member Identification #: *[insert number]*
DMH IS #: *[insert number]*

Dear [***Insert Applicant Name or Representative]***:

A decision has been made about your appeal about our decision to deny your application for the Healthy Way LA Program. The decision was made on [insert decision date].

After careful review, our reviewer does not agree with the original decision.

Your application has now been approved. You are covered by the HWLA Program as of [insert effective date]. You will be receiving a member package soon.

If you have any questions, please call DMH Patients' Rights at (213) 738-4949.

NOTE: If you cannot read or understand this letter, call Patients' Rights at (213) 738-4949. If you have trouble hearing or speaking, use TTY/TDD at (800) 735-2929.

Sincerely,

_____

(Name of RMD Representative)

c: DMH Patients' Rights